Proxy Consent for Medical Treatment

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], hereby appoint [Proxy's Full Name], residing at [Proxy's Address], as my Proxy for the purpose of giving consent to medical treatment on my behalf.

This proxy consent is granted in the event that I am unable to provide my own consent due to medical incapacity. My Proxy shall have the authority to make decisions regarding my medical treatment, including but not limited to, procedures, medications, and any other necessary medical interventions.

It is my wish that my Proxy act according to my known wishes, and if those wishes are not known, then in accordance with what they believe to be in my best interest.

This consent remains effective until [Specify Duration or Conditions for Termination].

Signed,

[Your Signature]

[Your Printed Name]

[Your Contact Information]

Witness:

_____

[Witness Full Name]

[Witness Address]

_____

[Witness Signature]